

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-007138

STATE FILE NUMBER

AMENDED

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 34

FILED FEB 20 1962

1. PLACE OF DEATH

a. COUNTY LIVINGSTON

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN CHILlicotheLength of stay in lb
1 YR.c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION SUSAN'S NURSINGHOMEInside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE MO.

b. COUNTY LIVINGSTON

c. CITY
OR TOWN CHILlicotheInside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
19 WEBSTER ST.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)First
EDWARDMiddle
R.Last
SHESTAK4. DATE
OF DEATHMonth
FEBRUARYDay
8,Year
19625. SEX
MALE6. COLOR OR RACE
WHITE7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐8. DATE OF BIRTH
12-14-18859. AGE (last birthday)
76IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done
or principal source of living, even if retired)
RETIRED FARMER10b. KIND OF BUSINESS OR INDUSTRY
FARMING11. BIRTHPLACE (City and state or country)
DORCHESTER, NEBR.12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

FRANK SHESTAK

13b. MOTHER'S MAIDEN NAME

ELIZABETH KUCERA

14. NAME OF HUSBAND OR WIFE

ANNA KASL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)
NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. Leo Shestak

Address
1210 MILLER AVE.
CHILlicothe, MO.18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

INTERVAL BETWEEN
ONSET AND DEATHPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 10-26-61 to Feb 8-62 and last saw him alive on Dec 24-61
Death occurred at 9:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

NORMAN FUNERAL HOME: Chillicothe, Mo.

Feb 9, 1962

Annalee Taylor

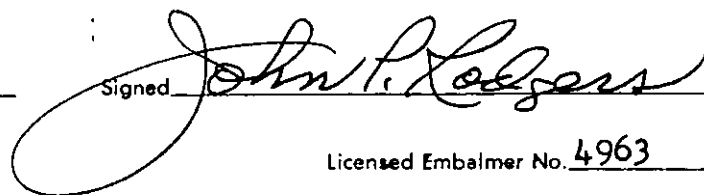
(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4963

P. O. Address CHILLICOTHE, MISS

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.